

Wakulla Urgent Care & Diagnostic Center
41 Feli Way, Crawfordville, FL 32327-2368
David A. Keen, M.D & Valerie M. Russell, ARNP

REGISTRATION FORM

(Please Print)

Today's Date:		Your Regular Doctor:			
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	Marital Status:	
				<input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid	
Is this your legal name	If not, what is legal name?	(Former name):		Birth Date:	Age:
<input type="checkbox"/> Yes <input type="checkbox"/> No					Sex:
					<input type="checkbox"/> M <input type="checkbox"/> F
Street address			Social Security #:	Home phone #:	
				()	
P.O. Box		City:	State:	Zip Code:	
Occupation:		Employer:		Employer phone #:	
				()	
E-mail Address:					
Referred by:		Language Spoken:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hawaiian or Other Pacific Islander <input type="checkbox"/> Other					

INSURANCE INFORMATION					
(Please give your insurance cards and picture ID to the receptionist.)					
Person responsible for bill:		Birth date:	Address (if different):		Home phone #:
					()
Is this person responsible for the bill a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone #:
					()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Primary Insurance:					
Subscriber's name:		Subscriber's S.S. No:	Birth Date:	Policy #:	Group #:
					Co-payment:
					\$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of Secondary Insurance (if applicable):		Subscriber's name:		Policy #:	Group #:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no:	Work phone no:	
			()	()	

I certify the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Wakulla Urgent Care & Diagnostic Center (Dr. David A. Keen and associates). I understand that I am financially responsible for all charges whether they are paid by my insurance or not. I also authorize the practice or the insurance companies to release any information, including health care data, required to process my claims.

 Patient/Guardian signature

 Date

Wakulla Urgent Care & Diagnostic Center
David A. Keen, M.D., M.P.H.

41 Feli Way

Crawfordville, Florida 32327

Phone: 850-926-3140 / Fax: 850-926-3163

Patient Name: _____ DOB: _____

PATIENT MEDICATION LIST
PLEASE LIST ALL MEDICATIONS CURRENTLY ON

Medication Name	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any known allergies to medications, if so please list:

Patient Signature: _____ Date: _____

HIPAA Authorization for Release of Information Wakulla Urgent Care & Diagnostic Center

I hereby authorize use or disclosure of protected health information about myself

(PATIENT NAME) _____ (DOB) _____ as described below.

The following people may receive any and all protected health information about myself:

_____ No One

Name	Date of Birth	Phone Number	Relationship

Which of the following communication means are appropriate/acceptable for WUC to communicate with you:
(Please check all that may apply)

- _____ Home Phone – Leave message to return call – no particulars
- _____ Home Phone – Leave message with particulars
- _____ Work Phone – Leave message to return call – no particulars
- _____ Work Phone – Leave message with particulars
- _____ Cell Phone # – _____ Leave message to return call – no particulars
- _____ Cell Phone # – _____ Leave message with particulars

In the case of an emergency, or if we are unable to reach you, whom may we contact?

Name: _____ Relationship: _____

Phone #: _____

Parent/Guardian Consent

In the event of my absence or availability, I hereby grant WUC permission to treat my child/ward _____ for any illness or injury he/she may encounter. In addition, in the event that I _____, the parent am not able to bring my child in for care, I grant _____ to bring my child in to be seen and treated by WUC. I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

I may revoke or withdraw this authorization by notifying **Wakulla Urgent Care & Diagnostic Center** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of patient or authorized representative

Date

Signature of Witness or Office Staff

Date

Wakulla Urgent Care & Diagnostic Center
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Date: _____

PATIENT CONSENT FORM

I hereby grant Wakulla Urgent Care permission to treat myself for any illness or injury I may encounter.

I understand that my medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim, and hereby assign benefits to Wakulla Urgent Care.

Signature: _____

Witness: _____

Please list two names and phone numbers to call in case of an emergency:

PARENT/GUARDIAN CONSENT FORM

In the event of my absence or availability, I hereby grant Wakulla Urgent Care permission to treat my child/ward _____ for any illness or injury he/she may encounter.

I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim; and hereby assign benefits to Wakulla Urgent Care.

Signature: _____

Witness: _____

Please list two names and phone numbers to call in case of an emergency:
